General

Guideline Title

Eating disorders: recognition and treatment.

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Eating disorders: recognition and treatment. London (UK): National Institute for Health and Care Excellence (NICE); 2017 May 23. 41 p. (NICE guideline; no. 69).

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: National Collaborating Centre for Mental Health. Eating disorders. Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. Leicester (UK): British Psychological Society; 2004. 260 p. [408 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests
	Guideline Development Group Composition

YES	Multidisciplinary Group
YES	Methodologist Involvement
▮▮▮▮▮	Patient and Public Perspectives
	Use of a Systematic Review of Evidence
▮▮▮▮▮	Search Strategy
▮▮▮▮▮	Study Selection
▮▮▮▮▮	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
▮▮▮▮▯	Grading the Quality or Strength of Evidence
▮▮▮▮▮	Benefits and Harms of Recommendations
▮▮▮▮▮	Evidence Summary Supporting Recommendations
▮▮▮▯▯	Rating the Strength of Recommendations
▮▮▮▮▮	Specific and Unambiguous Articulation of Recommendations
▮▮▮▮▮	External Review
▮▮▮▮▮	Updating

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Guideline Alliance (NGA) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation) and is defined at the end of the "Major Recommendations" field.

In this guideline, 'family members' includes the siblings, children and partners of people with an eating disorder.

General Principles of Care

Improving Access to Services

Be aware that people with an eating disorder may:

Find it difficult or distressing to discuss it with healthcare professionals, staff and other service

users
Be vulnerable to stigma and shame
Need information and interventions tailored to their age and level of development

Ensure that all people with an eating disorder and their parents or carers (as appropriate) have equal access to treatments (including through self-referral) for eating disorders, regardless of:

Age
Gender or gender identity (including people who are transgender)
Sexual orientation
Socioeconomic status
Religion, belief, culture, family origin or ethnicity
Where they live and who they live with
Any physical or other mental health problems or disabilities

Healthcare professionals assessing people with an eating disorder (especially children and young people) should be alert throughout assessment and treatment to signs of bullying, teasing, abuse (emotional, physical and sexual) and neglect. For guidance on when to suspect child maltreatment, see the National Institute for Health and Care Excellence (NICE) guideline on child maltreatment .

Communication and Information

When assessing a person with a suspected eating disorder, find out what they and their family members or carers (as appropriate) know about eating disorders and address any misconceptions.

Offer people with an eating disorder and their family members or carers (as appropriate) education and information on:

The nature and risks of the eating disorder and how it is likely to affect them
The treatments available and their likely benefits and limitations

When communicating with people with an eating disorder and their family members or carers (as appropriate):

Be sensitive when discussing a person's weight and appearance
Be aware that family members or carers may feel guilty and responsible for the eating disorder
Show empathy, compassion and respect
Provide information in a format suitable for them, and check they understand it

Ensure that people with an eating disorder and their parents or carers (as appropriate) understand the purpose of any meetings and the reasons for sharing information about their care with others.

Support for People with an Eating Disorder

Assess the impact of the home, education, work and wider social environment (including the internet and social media) on each person's eating disorder. Address their emotional, education, employment and social needs throughout treatment.

If appropriate, encourage family members, carers, teachers, and peers of children and young people to support them during their treatment.

Working with Family Members and Carers

Be aware that the family members or carers of a person with an eating disorder may experience severe distress. Offer family members or carers assessments of their own needs as treatment progresses, including:

What impact the eating disorder has on them and their mental health
What support they need, including practical support and emergency plans if the person with the eating disorder is at high medical or psychiatric risk

If appropriate, provide written information for family members or carers who do not attend assessment or treatment meetings with the person with an eating disorder.

Consent and Confidentiality

When working with people with an eating disorder and their family members or carers (as appropriate):

- Hold discussions in places where confidentiality, privacy and dignity can be respected
- Explain the limits of confidentiality (that is, which professionals and services have access to information about their care and when this may be shared with others)

When seeking consent for assessments or treatments for children or young people under 16, respect Gillick competence if they consent and do not want their family members or carers involved.

Training and Competencies

Professionals who assess and treat people with an eating disorder should be competent to do this for the age groups they care for.

Health, social care and education professionals working with people with an eating disorder should be trained and skilled in:

- Negotiating and working with family members and carers
- Managing issues around information sharing and confidentiality
- Safeguarding
- Working with multidisciplinary teams

Base the content, structure and duration of psychological treatments on relevant manuals that focus on eating disorders.

Professionals who provide treatments for eating disorders should:

- Receive appropriate clinical supervision
- Use standardised outcome measures, for example the Eating Disorder Examination Questionnaire (EDE-Q)
- Monitor their competence (for example by using recordings of sessions, and external audit and scrutiny)
- Monitor treatment adherence in people who use their service

Coordination of Care for People with an Eating Disorder

Take particular care to ensure services are well coordinated when:

- A young person moves from children's to adult services (see the NICE guideline on transition from children's to adults' services)
- More than one service is involved (such as inpatient and outpatient services, child and family services, or when a comorbidity is being treated by a separate service)
- People need care in different places at different times of the year (for example, university students)

Identification and Assessment

People with eating disorders should be assessed and receive treatment at the earliest opportunity.

Early treatment is particularly important for those with or at risk of severe emaciation and such patients should be prioritised for treatment.

Initial Assessments in Primary and Secondary Mental Health Care

Be aware that eating disorders present in a range of settings, including:

- Primary and secondary health care (including acute hospitals)
- Social care
- Education
- Work

Although eating disorders can develop at any age, be aware that the risk is highest for young men and women between 13 and 17 years of age.

Do not use screening tools (for example, sick, control, one stone, fat, food [SCOFF]) as the sole method to determine whether or not people have an eating disorder.

When assessing for an eating disorder or deciding whether to refer people for assessment, take into account any of the following that apply:

- An unusually low or high body mass index (BMI) or body weight for their age
- Rapid weight loss
- Dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying them, their family members or carers, or professionals
- Family members or carers report a change in eating behaviour
- Social withdrawal, particularly from situations that involve food
- Other mental health problems
- A disproportionate concern about their weight or shape (for example, concerns about weight gain as a side effect of contraceptive medication)
- Problems managing a chronic illness that affects diet, such as diabetes or coeliac disease
- Menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms
- Physical signs of:
  - Malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor
  - Compensatory behaviours, including laxative or diet pill misuse, vomiting or excessive exercise
- Abdominal pain that is associated with vomiting or restrictions in diet, and that cannot be fully explained by a medical condition
- Unexplained electrolyte imbalance or hypoglycaemia
- Atypical dental wear (such as erosion)
- Whether they take part in activities associated with a high risk of eating disorders (for example, professional sport, fashion, dance, or modelling)

Be aware that, in addition to the points in the recommendation above, children and young people with an eating disorder may also present with faltering growth (for example, a low weight or height for their age) or delayed puberty.

Do not use single measures such as BMI or duration of illness to determine whether to offer treatment for an eating disorder.

Professionals in primary and secondary mental health or acute settings should assess the following in people with a suspected eating disorder:

- Their physical health, including checking for any physical effects of malnutrition or compensatory behaviours such as vomiting
- The presence of mental health problems commonly associated with eating disorders, including depression, anxiety, self-harm and obsessive compulsive disorder
- The possibility of alcohol or substance misuse
- The need for emergency care in people whose physical health is compromised or who have a suicide risk

Referral

If an eating disorder is suspected after an initial assessment, refer immediately to a community-based, age-appropriate eating disorder service for further assessment or treatment.

Treating Anorexia Nervosa

Provide support and care for all people with anorexia nervosa in contact with specialist services, whether or not they are having a specific intervention. Support should:

- Include psychoeducation about the disorder
- Include monitoring of weight, mental and physical health, and any risk factors
- Be multidisciplinary and coordinated between services
- Involve the person's family members or carers (as appropriate)

When treating anorexia nervosa, be aware that:

- Helping people to reach a healthy body weight or BMI for their age is a key goal and
- Weight gain is key in supporting other psychological, physical and quality of life changes that are needed for improvement or recovery

When weighing people with anorexia nervosa, consider sharing the results with them and (if appropriate) their family members or carers.

Psychological Treatment for Anorexia Nervosa in Adults

For adults with anorexia nervosa, consider one of:

- Individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
- Specialist supportive clinical management (SSCM)

Explain to the person what the treatments involve to help them choose which they would prefer.

Individual CBT-ED programmes for adults with anorexia nervosa should:

- Typically consist of up to 40 sessions over 40 weeks, with twice-weekly sessions in the first 2 or 3 weeks
- Aim to reduce the risk to physical health and any other symptoms of the eating disorder
- Encourage healthy eating and reaching a healthy body weight
- Cover nutrition, cognitive restructuring, mood regulation, social skills, body image concern, self-esteem, and relapse prevention
- Create a personalised treatment plan based on the processes that appear to be maintaining the eating problem
- Explain the risks of malnutrition and being underweight
- Enhance self-efficacy
- Include self-monitoring of dietary intake and associated thoughts and feelings
- Include homework, to help the person practice in their daily life what they have learned

MANTRA for adults with anorexia nervosa should:

- Typically consist of 20 sessions, with:
  - Weekly sessions for the first 10 weeks, and a flexible schedule after this
  - Up to 10 extra sessions for people with complex problems
- Base treatment on the MANTRA workbook
- Motivate the person and encourage them to work with the practitioner
- Be flexible in how the modules of MANTRA are delivered and emphasised
- When the person is ready, cover nutrition, symptom management, and behaviour change
- Encourage the person to develop a 'non-anorexic identity'
- Involve family members or carers to help the person:
  - Understand their condition and the problems it causes and the link to the wider social context
  - Change their behaviour

SSCM for adults with anorexia nervosa should:

- Typically consist of 20 or more weekly sessions (depending on severity)
- Assess, identify, and regularly review key problems
- Aim to develop a positive relationship between the person and the practitioner
- Aim to help people recognise the link between their symptoms and their abnormal eating behaviour
- Aim to restore weight
- Provide psychoeducation, and nutritional education and advice
- Include physical health monitoring
- Establish a weight range goal
- Encourage reaching a healthy body weight and healthy eating
- Allow the person to decide what else should be included as part of their therapy

If individual CBT-ED, MANTRA, or SSCM is unacceptable, contraindicated or ineffective for adults with anorexia nervosa, consider:

- One of these 3 treatments that the person has not had before or
- Eating-disorder-focused focal psychodynamic therapy (FPT)

FPT for adults with anorexia nervosa should:

- Typically consist of up to 40 sessions over 40 weeks
- Make a patient-centred focal hypothesis that is specific to the individual and addresses:
  - What the symptoms mean to the person
  - How the symptoms affect the person
  - How the symptoms influence the person's relationships with others and with the therapist
- In the first phase, focus on developing the therapeutic alliance between the therapist and person with anorexia nervosa, addressing pro-anorexic behaviour and egosyntonic beliefs (beliefs, values and feelings consistent with the person's sense of self) and building self-esteem
- In the second phase, focus on relevant relationships with other people and how these affect eating behaviour
- In the final phase, focus on transferring the therapy experience to situations in everyday life and address any concerns the person has about what will happen when treatment ends

Psychological Treatment for Anorexia Nervosa in Children and Young People

Consider anorexia-nervosa-focused family therapy for children and young people (FT-AN), delivered as single-family therapy or a combination of single- and multi-family therapy. Give children and young people the option to have some single-family sessions:

- Separately from their family members or carers and
- Together with their family members or carers

FT-AN for children and young people with anorexia nervosa should:

- Typically consist of 18 to 20 sessions over 1 year
- Review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last
- Emphasise the role of the family in helping the person to recover
- Not blame the person or their family members or carers
- Include psychoeducation about nutrition and the effects of malnutrition
- Early in treatment, support the parents or carers to take a central role in helping the person manage their eating, and emphasise that this is a temporary role
- In the first phase, aim to establish a good therapeutic alliance with the person, their parents or carers and other family members
- In the second phase, support the person (with help from their parents or carers) to establish a level of independence appropriate for their level of development
- In the final phase:
  - Focus on plans for when treatment ends (including any concerns the person and their family

have) and on relapse prevention
Address how the person can get support if treatment is stopped

Consider support for family members who are not involved in the family therapy, to help them cope with distress caused by the condition.

Consider giving children and young people with anorexia nervosa additional appointments separate from their family members or carers.

Assess whether family members or carers (as appropriate) need support if the child or young person with anorexia nervosa is having therapy on their own.

If FT-AN is unacceptable, contraindicated or ineffective for children or young people with anorexia nervosa, consider individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN).

Individual CBT-ED for children and young people with anorexia nervosa should:

Typically consist of up to 40 sessions over 40 weeks, with:
Twice-weekly sessions in the first 2 or 3 weeks
8 to 12 additional brief family sessions with the person and their parents or carers (as appropriate)
In family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition
In family sessions:
Identify anything in the person's home life that could make it difficult for them to change their behaviour, and find ways to address this
Discuss meal plans
Aim to reduce the risk to physical health and any other symptoms of the eating disorder
Encourage reaching a healthy body weight and healthy eating
Cover nutrition, relapse prevention, cognitive restructuring, mood regulation, social skills, body image concern and self-esteem
Create a personalised treatment plan based on the processes that appear to be maintaining the eating problem
Take into account the person's specific development needs
Explain the risks of malnutrition and being underweight
Enhance self-efficacy
Include self-monitoring of dietary intake and associated thoughts and feelings
Include homework, to help the person practice what they have learned in their daily life
Address how the person can get support if treatment is stopped

AFP-AN for children and young people should:

Typically consist of 32 to 40 individual sessions over 12 to 18 months, with:
More regular sessions early on, to help the person build a relationship with the practitioner and motivate them to change their behaviour
8 to 12 additional family sessions with the person and their parents or carers (as appropriate)
Review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last
In family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition
Focus on the person's self-image, emotions and interpersonal processes, and how these affect their eating disorder
Develop a formulation of the person's psychological issues and how they use anorexic behaviour as a coping strategy
Address fears about weight gain, and emphasise that weight gain and healthy eating is a critical part of therapy
Find alternative strategies for the person to manage stress

- In later stages of treatment, explore issues of identity and build independence
- Towards end of treatment, focus on transferring the therapy experience to situations in everyday life
- In family sessions, help parents or carers support the person to change their behaviour
- Address how the person can get support if treatment is stopped

People with Anorexia Nervosa Who Are Not Having Treatment

For people with anorexia who are not having treatment (for example because it has not helped or because they have declined it) and who do not have severe or complex problems:

- Discharge them to primary care
- Tell them they can ask their general practitioner (GP) to refer them again for treatment at any time

For people with anorexia who have declined or do not want treatment and who have severe or complex problems, eating disorder services should provide support as covered in the first recommendation of the "Treating Anorexia Nervosa" section.

Dietary Advice for People with Anorexia Nervosa

Only offer dietary counselling as part of a multidisciplinary approach.

Encourage people with anorexia nervosa to take an age-appropriate oral multivitamin and multi-mineral supplement until their diet includes enough to meet their dietary reference values.

Include family members or carers (as appropriate) in any dietary education or meal planning for children and young people with anorexia nervosa who are having therapy on their own.

Offer supplementary dietary advice to children and young people with anorexia nervosa and their family or carers (as appropriate) to help them meet their dietary needs for growth and development (particularly during puberty).

Medication for Anorexia Nervosa

Do not offer medication as the sole treatment for anorexia nervosa.

Treating Binge Eating Disorder

Psychological Treatment for Binge Eating Disorder in Adults

Explain to people with binge eating disorder that psychological treatments aimed at treating binge eating have a limited effect on body weight and that weight loss is not a therapy target in itself. Refer to the NGC summary of the NICE guideline Obesity: identification, assessment and management of overweight and obesity in children, young people and adults for guidance on weight loss and bariatric surgery.

Offer a binge-eating-disorder-focused guided self-help programme to adults with binge eating disorder.

Binge-eating-disorder-focused guided self-help programmes for adults should:

- Use cognitive behavioural self-help materials
- Focus on adherence to the self-help programme
- Supplement the self-help programme with brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first)
- Focus exclusively on helping the person follow the programme

If guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks, offer group eating-disorder-focused cognitive behavioural therapy (CBT-ED).

Group CBT-ED programmes for adults with binge eating disorder should:

- Typically consist of 16 weekly 90-minute group sessions over 4 months
- Focus on psychoeducation, self-monitoring of the eating behaviour and helping the person analyse

their problems and goals
Include making a daily food intake plan and identifying binge eating cues
Include body exposure training and helping the person to identify and change negative beliefs about their body
Help with avoiding relapses and coping with current and future risks and triggers

If group CBT-ED is not available or the person declines it, consider individual CBT-ED for adults with binge eating disorder.

Individual CBT-ED for adults with binge eating disorder should:

Typically consist of 16 to 20 sessions
Develop a formulation of the person's psychological issues, to determine how dietary and emotional factors contribute to their binge eating
Based on the formulation:
Advise people to eat regular meals and snacks to avoid feeling hungry
Address the emotional triggers for their binge eating, using cognitive restructuring, behavioural experiments and exposure
Include weekly monitoring of binge eating behaviours, dietary intake and weight
Share the weight record with the person
Address body-image issues if present
Explain to the person that although CBT-ED does not aim at weight loss, stopping binge eating can have this effect in the long term
Advise the person not to try to lose weight (for example by dieting) during treatment, because this is likely to trigger binge eating

Psychological Treatment for Binge Eating Disorder in Children and Young People

For children and young people with binge eating disorder, offer the same treatments recommended for adults with binge eating disorder.

Medication for Binge Eating Disorder

Do not offer medication as the sole treatment for binge eating disorder.

Treating Bulimia Nervosa

Explain to all people with bulimia nervosa that psychological treatments have a limited effect on body weight.

Psychological Treatment for Bulimia Nervosa in Adults

Consider bulimia-nervosa-focused guided self-help for adults with bulimia nervosa.

Bulimia-nervosa-focused guided self-help programmes for adults with bulimia nervosa should:

Use cognitive behavioural self-help materials for eating disorders
Supplement the self-help programme with brief supportive sessions (for example 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first)

If bulimia-nervosa-focused guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks of treatment, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED).

Individual CBT-ED for adults with bulimia nervosa should:

Typically consist of up to 20 sessions over 20 weeks, and consider twice-weekly sessions in the first phase
In the first phase focus on:
Engagement and education
Establishing a pattern of regular eating, and providing encouragement, advice and support while

- people do this
- Follow by addressing the eating disorder psychopathology (for example, the extreme dietary restraint, the concerns about body shape and weight, and the tendency to binge eat in response to difficult thoughts and feelings)
- Towards the end of treatment, spread appointments further apart and focus on maintaining positive changes and minimising the risk of relapse
- If appropriate, involve significant others to help with one-to-one treatment

Psychological Treatment for Bulimia Nervosa in Children and Young People

Offer bulimia-nervosa-focused family therapy (FT-BN) to children and young people with bulimia nervosa.

FT-BN for children and young people with bulimia nervosa should:

- Typically consist of 18 to 20 sessions over 6 months
- Establish a good therapeutic relationship with the person and their family members or carers
- Support and encourage the family to help the person recover
- Not blame the person, their family members or carers
- Include information about:
  - Regulating body weight
  - Dieting
  - The adverse effects of attempting to control weight with self-induced vomiting, laxatives or other compensatory behaviours
- Use a collaborative approach between the parents and the young person to establish regular eating patterns and minimise compensatory behaviours
- Include regular meetings with the person on their own throughout the treatment
- Include self-monitoring of bulimic behaviours and discussions with family members or carers
- In later phases of treatment, support the person and their family members or carers to establish a level of independence appropriate for their level of development
- In the final phase of treatment, focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention

Consider support for family members who are not involved in the family therapy, to help them to cope with distress caused by the condition.

If FT-BN is unacceptable, contraindicated or ineffective, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) for children and young people with bulimia nervosa.

Individual CBT-ED for children and young people with bulimia nervosa should:

- Typically consist of 18 sessions over 6 months, with more frequent sessions early in treatment
- Include up to 4 additional sessions with parents or carers
- Initially focus on the role bulimia nervosa plays in the person's life and on building motivation to change
- Provide psychoeducation about eating disorders and how symptoms are maintained, while encouraging the person to gradually establish regular eating habits
- Develop a case formulation with the person
- Teach the person to monitor their thoughts, feelings and behaviours
- Set goals and encourage the person to address problematic thoughts, beliefs and behaviours with problem-solving
- Use relapse prevention strategies to prepare for and mitigate potential future setbacks
- In sessions with parents and carers, provide education about eating disorders, identify family factors that stop the person from changing their behaviour, and discuss how the family can support the person's recovery.

Medication for Bulimia Nervosa

Do not offer medication as the sole treatment for bulimia nervosa.

Treating Other Specified Feeding and Eating Disorders (OSFED)

For people with OSFED, consider using the treatments for the eating disorder it most closely resembles.

Physical Therapy for Any Eating Disorder

Do not offer a physical therapy (such as transcranial magnetic stimulation, acupuncture, weight training, yoga or warming therapy) as part of the treatment for eating disorders.

Physical and Mental Health Comorbidities

Eating disorder specialists and other healthcare teams should collaborate to support effective treatment of physical or mental health comorbidities in people with an eating disorder.

When collaborating, teams should use outcome measures for both the eating disorder and the physical and mental health comorbidities, to monitor the effectiveness of treatments for each condition and the potential impact they have on each other.

Diabetes

For people with an eating disorder and diabetes, the eating disorder and diabetes teams should:

- Collaborate to explain the importance of physical health monitoring to the person
- Agree who has responsibility for monitoring physical health
- Collaborate on managing mental and physical health comorbidities
- Use a low threshold for monitoring blood glucose and blood ketones
- Use outcome measurements to monitor the effectiveness of treatments for each condition and the potential impact they have on each other

When treating eating disorders in people with diabetes:

- Explain to the person (and if needed their diabetes team) that they may need to monitor their blood glucose and blood ketones more closely during treatment
- Consider involving their family members and carers (as appropriate) in treatment to help them with blood glucose control

Address insulin misuse as part of any psychological treatment for eating disorders in people with diabetes.

Offer people with an eating disorder who are misusing insulin the following treatment plan:

- A gradual increase in the amount of carbohydrates in their diet (if medically safe), so that insulin can be started at a lower dose
- A gradual increase in insulin doses to avoid a rapid drop in blood glucose levels, which can increase the risk of retinopathy and neuropathy
- Adjusted total glycaemic load and carbohydrate distribution to meet their individual needs and prevent rapid weight gain
- Psychoeducation about the problems caused by misuse of diabetes medication
- Diabetes educational interventions, if the person has any gaps in their knowledge

For people with suspected hypoglycaemia, test blood glucose:

- Before all supervised meals and snacks
- When using the hypoglycaemia treatment algorithm
- After correction doses

For people with suspected hyperglycaemia or hypoglycaemia, and people with normal blood glucose levels who are misusing insulin, healthcare professionals should test for blood ketones:

- When using the hypoglycaemia treatment algorithm
- After correction doses

For people with bulimia nervosa and diabetes, consider monitoring of:

- Glucose toxicity
- Insulin resistance
- Ketoacidosis
- Oedema

When diabetes control is challenging:

- Do not attempt to rapidly treat hyperglycaemia (for example with increased insulin doses), because this increases the risk of retinopathy and neuropathy
- Regularly monitor blood potassium levels
- Do not stop insulin altogether, because this puts the person at high risk of diabetic ketoacidosis

For more guidance on managing diabetes, including on fluid replacement in children and young people with diabetic ketoacidosis, refer to the NGC summaries of the NICE guidelines Diabetes (type 1 and type 2) in children and young people, Type 1 diabetes in adults: diagnosis and management, and Type 2 diabetes in adults: management.

Comorbid Mental Health Problems

When deciding which order to treat an eating disorder and a comorbid mental health condition (in parallel, as part of the same treatment plan or one after the other), take the following into account:

- The severity and complexity of the eating disorder and comorbidity
- The person's level of functioning
- The preferences of the person with the eating disorder and (if appropriate) those of their family members or carers

Refer to the NICE guidelines on specific mental health problems for further guidance on treatment.

Medication Risk Management

When prescribing medication for people with an eating disorder and comorbid mental or physical health conditions, take into account the impact malnutrition and compensatory behaviours can have on medication effectiveness and the risk of side effects.

When prescribing for people with an eating disorder and a comorbidity, assess how the eating disorder will affect medication adherence (for example, for medication that can affect body weight).

When prescribing for people with an eating disorder, take into account the risks of medication that can compromise physical health due to pre-existing medical complications.

Offer electrocardiogram (ECG) monitoring for people with an eating disorder who are taking medication that could compromise cardiac functioning (including medication that could cause electrolyte imbalance, bradycardia below 40 beats per minute, hypokalaemia, or a prolonged QT interval).

Substance or Medication Misuse

For people with an eating disorder who are misusing substances, or over the counter or prescribed medication, provide treatment for the eating disorder unless the substance misuse is interfering with this treatment.

If substance misuse or medication is interfering with treatment, consider a multidisciplinary approach with substance misuse services.

Growth and Development

Seek specialist paediatric or endocrinology advice for delayed physical development or faltering growth in children and young people with an eating disorder.

Conception and Pregnancy for Women with Eating Disorders

Provide advice and education to women with an eating disorder who plan to conceive, to increase the likelihood of conception and to reduce the risk of miscarriage. This may include information on the importance of:

- Maintaining good mental health and wellbeing
- Ensuring adequate nutrient intake and a healthy body weight
- Stopping behaviours such as binge eating, vomiting, laxatives and excessive exercise

Nominate a dedicated professional (such as a GP or midwife) to monitor and support pregnant women with an eating disorder during pregnancy and in the post-natal period, because of:

- Concerns they may have specifically about gaining weight
- Possible health risks to the mother and child
- The high risk of mental health problems in the perinatal period

For women who are pregnant or in the perinatal period and have an eating disorder:

- Offer treatment for their eating disorder as covered in sections on anorexia nervosa, binge eating disorder, bulimia nervosa, and OSFED
- Provide monitoring and education as recommended in the NICE guideline on antenatal and postnatal mental health

For guidance on providing advice to pregnant women about healthy eating and feeding their baby, see the NICE guideline on maternal and child nutrition.

Consider more intensive prenatal care for pregnant women with current or remitted anorexia nervosa, to ensure adequate prenatal nutrition and fetal development.

Physical Health Assessment, Monitoring and Management for Eating Disorders

Physical Health Assessment and Monitoring for All Eating Disorders

Assess fluid and electrolyte balance in people with an eating disorder who are believed to be engaging in compensatory behaviours, such as vomiting, taking laxatives or diuretics, or water loading.

Assess whether ECG monitoring is needed in people with an eating disorder, based on the following risk factors:

- Rapid weight loss
- Excessive exercise
- Severe purging behaviours, such as laxative or diuretic use or vomiting
- Bradycardia
- Hypotension
- Excessive caffeine (including from energy drinks)
- Prescribed or non-prescribed medications
- Muscular weakness
- Electrolyte imbalance
- Previous abnormal heart rhythm

Management for All Eating Disorders

Provide acute medical care (including emergency admission) for people with an eating disorder who have severe electrolyte imbalance, severe malnutrition, severe dehydration or signs of incipient organ failure.

For people with an eating disorder who need supplements to restore electrolyte balance, offer these orally unless the person has problems with gastrointestinal absorption or the electrolyte disturbance is severe.

For people with an eating disorder and continued unexplained electrolyte imbalance, assess whether it could be caused by another condition.

Encourage people with an eating disorder who are vomiting to:

- Have regular dental and medical reviews
- Avoid brushing teeth immediately after vomiting
- Rinse with non-acid mouthwash after vomiting
- Avoid highly acidic foods and drinks

Advise people with an eating disorder who are misusing laxatives or diuretics:

- That laxatives and diuretics do not reduce calorie absorption and so do not help with weight loss
- To gradually reduce and stop laxative or diuretic use

Advise people with an eating disorder who are exercising excessively to stop doing so.

For guidance on identifying, assessing and managing overweight and obesity, see the NGC summary of the NICE guideline Obesity: identification, assessment and management of overweight and obesity in children, young people and adults.

Assessment and Monitoring of Physical Health in Anorexia Nervosa

GPs should offer a physical and mental health review at least annually to people with anorexia nervosa who are not receiving ongoing treatment for their eating disorder. The review should include:

- Weight or BMI (adjusted for age if appropriate)
- Blood pressure
- Relevant blood tests
- Any problems with daily functioning
- Assessment of risk (related to both physical and mental health)
- An ECG, for people with purging behaviours and/or significant weight changes
- A discussion of treatment options

Monitor growth and development in children and young people with anorexia nervosa who have not completed puberty (for example, not reached menarche or final height).

Low Bone Mineral Density in People with Anorexia Nervosa

Bone mineral density results should be interpreted and explained to people with anorexia nervosa by a professional with the knowledge and competencies to do this.

Before deciding whether to measure bone density, discuss with the person and their family members or carers why it could be useful.

Explain to people with anorexia nervosa that the main way of preventing and treating low bone mineral density is reaching and maintaining a healthy body weight or BMI for their age.

Consider a bone mineral density scan:

- After 1 year of underweight in children and young people, or earlier if they have bone pain or recurrent fractures
- After 2 years of underweight in adults, or earlier if they have bone pain or recurrent fractures

Use measures of bone density that correct for bone size (such as bone mineral apparent density [BMAD]) in children and young people with faltering growth.

Consider repeat bone mineral density scans in people with ongoing persistent underweight, especially when using or deciding whether to use hormonal treatment.

Do not repeat bone mineral density scans for people with anorexia nervosa more frequently than once per

year, unless they develop bone pain or recurrent fractures.

Do not routinely offer oral or transdermal oestrogen therapy to treat low bone mineral density in children or young people with anorexia nervosa.

Seek specialist paediatric or endocrinological advice before starting any hormonal treatment for low bone mineral density. Coordinate any treatment with the eating disorders team.

Consider transdermal 17-β-estradiol (with cyclic progesterone) for young women (13–17 years) with anorexia nervosa who have long-term low body weight and low bone mineral density with a bone age over 15.

Consider incremental physiological doses of oestrogen in young women (13–17 years) with anorexia nervosa who have delayed puberty, long-term low body weight and low bone mineral density with a bone age under 15.

Consider bisphosphonates for women (18 years and over) with anorexia nervosa who have long-term low body weight and low bone mineral density. Discuss the benefits and risks (including risk of teratogenic effects) with women before starting treatment.

Advise people with anorexia nervosa and osteoporosis or related bone disorders to avoid high-impact physical activities and activities that significantly increase the chance of falls or fractures.

For guidance on osteoporosis risk assessment, see the NGC summary of the NICE guideline Osteoporosis: assessing the risk of fragility fracture.

Inpatient and Day Patient Treatment

Admit people with an eating disorder whose physical health is severely compromised to a medical inpatient or day patient service for medical stabilisation and to initiate refeeding, if these cannot be done in an outpatient setting.

Do not use an absolute weight or BMI threshold when deciding whether to admit people with an eating disorder to day patient or inpatient care.

When deciding whether day patient or inpatient care is most appropriate, take the following into account:

- The person's BMI or weight, and whether these can be safely managed in a day patient service or whether the rate of weight loss (for example more than 1 kg a week) means they need inpatient care.
- Whether inpatient care is needed to actively monitor medical risk parameters such as blood tests, physical observations and ECG (for example bradycardia below 40 beats per minute or a prolonged QT interval) that have values or rates of change in the concern or alert ranges: refer to Box 1 in Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) , or Guidance 1 and 2 in Junior MARSIPAN .
- The person's current physical health and whether this is significantly declining
- Whether the parents or carers of children and young people can support them and keep them from significant harm as a day patient

When reviewing the need for inpatient care as part of an integrated treatment programme for a person with an eating disorder:

- Do not use inpatient care solely to provide psychological treatment for eating disorders
- Do not discharge people solely because they have reached a healthy weight

For people with an eating disorder and acute mental health risk (such as significant suicide risk), consider psychiatric crisis care or psychiatric inpatient care.

Children, young people and adults with an eating disorder who are admitted to day patient or inpatient care should be cared for in age-appropriate facilities (for example, paediatric wards or adolescent mental

health services). These should be near to their home, and have the capacity to provide appropriate educational activities during extended admissions.

When a person is admitted to inpatient care for medical stabilisation, specialist eating disorder or liaison psychiatry services should:

- Keep in contact with the inpatient team to advise on care and management, both during the admission and when planning discharge
- Keep the person's family members or carers involved
- Consider starting or continuing psychological treatments for the eating disorder

Inpatient or day patient services should collaborate with other teams (including the community team) and the person's family members or carers (as appropriate), to help with treatment and transition.

Refeeding

Ensure that staff of day patient, inpatient, or acute services who treat eating disorders are trained to recognise the symptoms of refeeding syndrome and how to manage it.

Use a standard operating procedure for refeeding that emphasises the need to avoid under-nutrition and refeeding syndrome. Refer to existing national guidance, such as MARSIPAN and Junior MARSIPAN.

Care Planning and Discharge from Inpatient Care

Develop a care plan for each person with an eating disorder who is admitted to inpatient care. The care plan should:

- Give clear objectives and outcomes for the admission
- Be developed in collaboration with the person, their family members or carers (as appropriate), and the community-based eating disorder service
- Set out how they will be discharged, how they will move back to community-based care, and what this care should be

Whether or not the person is medically stable, within 1 month of admission review with them, their parents or carers (as appropriate) and the referring team, whether inpatient care should be continued or stepped down to a less intensive setting.

As part of the review:

- Assess whether enough progress has been made towards the objectives agreed at admission
- Agree a schedule for further reviews, with reviews happening at least monthly
- Take into account the risk that people with an eating disorder can become institutionalised by a long admission, and that a lack of change in their condition could indicate that inpatient treatment is harmful
- Consider seeking an independent second opinion if healthcare professionals have different views about the benefit of continued inpatient care

Using the Mental Health Act and Compulsory Treatment

If a person's physical health is at serious risk due to their eating disorder, they do not consent to treatment, and they can only be treated safely in an inpatient setting, follow the legal framework for compulsory treatment in the Mental Health Act 1983.

If a child or young person lacks capacity, their physical health is at serious risk and they do not consent to treatment, ask their parents or carers to consent on their behalf and if necessary, use an appropriate legal framework for compulsory treatment (such as the Mental Health Act 1983/2007 or the Children Act 1989).

Feeding people without their consent should only be done by multidisciplinary teams who are competent

to do so.

Definitions

Strength of Recommendations

Some recommendations can be made with more certainty than others, depending on the quality of the underpinning evidence. The Committee makes a recommendation based on the trade-off between the benefits and harms of a system, process or an intervention, taking into account the quality of the underpinning evidence. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The Committee usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally the Committee uses 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The Committee uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of people, a system, process or an intervention will do more good than harm, and be cost effective. Similar forms of words (for example, 'Do not offer…') are used when the Committee is confident that an intervention will not be of benefit for most people.

Interventions That Could Be Used

The Committee uses 'consider' when confident that a system, process or an intervention will do more good than harm for most people, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the person's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the person.

Clinical Algorithm(s)

A National Institute for Health and Care Excellence (NICE) pathway titled "Eating disorders overview" is provided on the NICE Web site .

Scope

Disease/Condition(s)

Eating disorders including anorexia nervosa, binge eating disorder, bulimia nervosa, and other specified feeding and eating disorder (OSFED)

Other Disease/Condition(s) Addressed

- Diabetes
- Mental health conditions

Guideline Category

Diagnosis

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Endocrinology

Family Practice

Internal Medicine

Nutrition

Obstetrics and Gynecology

Pediatrics

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Dietitians

Emergency Medical Technicians/Paramedics

Health Care Providers

Hospitals

Nurses

Occupational Therapists

Patients

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Guideline Objective(s)

- To provide recommendations on assessment, treatment, monitoring and inpatient care for children, young people and adults with eating disorders
- To improve the care people receive by detailing the most effective treatments for anorexia nervosa,

binge eating disorder and bulimia nervosa

Target Population

Children (0–12 years), young people (13–17 years), and adults (18 years and over), with an eating disorder, including atypical presentations, or a suspected eating disorder

Note: Groups that will not be covered:

People with disordered eating because of a separate physical or other primary mental health problem of which a disorder of eating is a symptom
People with feeding disorders, such as avoidant restrictive food intake disorders
People with obesity without an eating disorder

Interventions and Practices Considered

1. General principles of care
    - Improving access to service
    - Providing education and information
    - Showing sensitivity and empathy when communicating with people with an eating disorder and family members/carers
    - Providing support for people with eating disorders
    - Working with family members/carers
    - Obtaining consent for treatment and ensuring confidentiality
    - Ensuring competency of professionals who assess and provide treatment of people with eating disorders
    - Coordination of care
2. Identification and assessment
    - Initial assessments in primary and secondary mental health care
    - Immediate referral to a community-based, age-appropriate eating disorder service for further assessment or treatment
3. Treatment
    - Providing support and care
    - Psychological treatment
        - Individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)
        - Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
        - Specialist supportive clinical management (SSCM)
        - Eating-disorder-focused focal psychodynamic therapy (FPT)
        - Anorexia-nervosa-focused family therapy for children and young people (FT-AN)
        - Adolescent-focused psychotherapy for anorexia nervosa (AFP-AN)
        - Bulimia-nervosa-focused family therapy (FT-BN)
        - Guided self-help programmes and self-help materials
    - Discharge to primary care for people not having treatment
    - Dietary counselling as part of a multidisciplinary approach
    - Medications for eating disorders (not recommended as sole treatment)
    - Physical therapy (such as transcranial magnetic stimulation, acupuncture, weight training, yoga or warming therapy) as part of the treatment for eating disorders (not recommended)
4. Management of physical and mental health comorbidities
    - Collaboration between eating disorder specialists and other healthcare teams
    - Considerations for people with eating disorders and comorbidities
        - Diabetes (monitoring for insulin misuse, hypoglycaemia, hyperglycaemia, ketoacidosis)
        - Comorbid mental health problems
        - Medication risk management
        - Substance and medication misuse
        - Growth and development

5. Conception and pregnancy for women with eating disorders
    - Providing advice and education to women with an eating disorder who plan to conceive
    - Nominating a dedicated professional (such as a GP or midwife) to monitor and support pregnant women with an eating disorder during pregnancy and in the post-natal period
    - Treating and managing the eating disorder in the perinatal period
6. Physical health assessment, monitoring and management for eating disorders
    - Physical health assessment and monitoring for all eating disorders
        - Assessment of fluid and electrolyte balance
        - Electrocardiography (ECG) monitoring
    - Encouraging regular dental and oral care
    - Providing advice on laxative and diuretic misuse and excessive exercise
    - Assessment and monitoring of physical health in anorexia nervosa (weight, body mass index, growth and development in children and young people)
    - Assessment and management of low bone mineral density in people with anorexia nervosa
7. Inpatient and day patient treatment
    - Considerations for admission to inpatient or day patient treatment
    - Refeeding
    - Care planning and discharge from inpatient care
8. Using the Mental Health Act and compulsory treatment
    - Legal framework for compulsory treatment
    - Feeding people without their consent

Major Outcomes Considered

- Sensitivity, specificity, and positive and negative predictive value of case-identification tools
- All-cause mortality
- Remission and long-term recovery
- Relapse rates
- General functioning, measured by return to normal activities, or by general mental health 24 functioning measures such as Global Assessment of Functioning (GAF)
- Cognitive distortion (evidence of ongoing preoccupation with weight/shape/food/eating)
- Weight and body mass index
- Family functioning
- Quality of life
- Growth/bone density
- Service user experience
- Cost-effectiveness of treatment
- Resource use

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Guideline Alliance (NGA) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Clinical Review Methods

The Search Process

Scoping Searches

A broad preliminary search of the literature was undertaken in January 2015 to obtain an overview of the issues likely to be covered by the scope and to help define key areas. The searches were restricted to clinical guidelines, Health Technology Assessment (HTA) reports, key systematic reviews and randomised controlled trials (RCTs). A list of databases and websites searched can be found in Appendix H.

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate as much relevant evidence as possible. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered and a decision made to utilise a broad approach to searching to maximise retrieval of evidence to all parts of the guideline. Searches were restricted to certain study designs if specified in the review protocol and conducted in the following databases:

Cochrane Database of Abstracts of Reviews of Effects
Cochrane Database of Systematic Reviews
Cochrane Central Register of Controlled Trials
Excerpta Medica Database (EMBASE)
HTA database (technology assessments)
Medical Literature Analysis and Retrieval System Online (MEDLINE)/MEDLINE In-29 Process
Psychological Information Database (PsycINFO)

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up through a number of trial searches and discussions of the results of the searches with the review team and committee to ensure that all possible relevant search terms were covered. In order to assure comprehensive coverage, search terms for mental health and learning disabilities were kept purposely broad to help counter dissimilarities in database indexing practices and thesaurus terms and imprecise reporting of study populations by authors in the titles and abstracts of records. The search terms for each search are set out in full in Appendix H.

Reference Management

Citations from each search were downloaded into reference management software and duplicates removed. Records were then screened against the eligibility criteria of the reviews before being appraised for methodological quality. The unfiltered search results were saved and retained for future potential re-analysis to help keep the process both replicable and transparent.

Search Filters

To aid retrieval of relevant and sound studies, filters were used to limit a number of searches to systematic reviews, RCTs and observational. The search filters for systematic reviews and RCTs are adaptations of validated filters designed by the Health Information Research Unit (HIRU) at McMaster University. The search filter for observational studies is an in-house development. The filters have been recorded and can be found in Appendix H.

Date and Language Restrictions

Systematic database searches were initially conducted in May 2015 up to the most recent searchable

date. Search updates were generated on a six monthly basis, with the final re-runs carried out in July 2016 ahead of the guideline consultation. After this point, studies were only included if they were judged by the committee to be exceptional (for example, if the evidence was likely to change a recommendation).

Although no language restrictions were applied at the searching stage, foreign language papers were not requested or reviewed, unless they were of particular importance to a review question.

Date restrictions were not applied, except for searches of systematic reviews which were limited to research published from 2001. The search for systematic reviews was restricted to the last 15 years as older reviews were thought to be less useful.

Other Search Methods

Other search methods involved: (a) scanning the reference lists of all eligible publications (systematic reviews, stakeholder evidence and included studies) for more published reports and citations of unpublished research; (b) sending lists of studies meeting the inclusion criteria to subject experts (identified through searches and the committee) and asking them to check the lists for completeness and to provide information of any published or unpublished research for consideration (see Appendix E); (c) checking the tables of contents of key journals for studies that might have been missed by the database and reference list searches; (d) tracking key papers in the Science Citation Index (prospectively) over time for further useful references; (e) conducting searches in ClinicalTrials.gov for unpublished trial reports; (f) contacting included study authors for unpublished or incomplete datasets. Searches conducted for existing NICE guidelines were updated where necessary. Other relevant guidelines were assessed for quality using the AGREE (Appraisal of Guidelines for Research and Evaluation) instrument. The evidence base underlying high-quality existing guidelines was utilised and updated as appropriate.

Study Selection and Assessment of Methodological Quality

All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time they were being entered into the study information database. Eligible systematic reviews and primary-level studies were critically appraised for methodological quality (risk of bias) using a checklist (NICE, 2012a) for templates. However, some checklists that were recommended in the 2014 manual update (NICE, 2014) were used (for example, for qualitative studies, for systematic reviews [Assessing the Methodological Quality of Systematic Reviews, AMSTAR, checklist] and for cross-sectional and cohort studies [the Newcastle Ottawa checklist for observational studies was used for the epidemiological review on incidence and prevalence).

The Quality Assessment of Diagnostic Accuracy Studies – Revised (QUADAS-II) was used for evaluating risk of bias and indirectness of diagnostic and assessment tool studies.

For some review questions, it was necessary to prioritise the evidence with respect to the UK context (that is, external validity). To make this process explicit, the committee took into account the following factors when assessing the evidence:

- Participant factors (for example, gender, age and ethnicity)
- Provider factors (for example, model fidelity, the conditions under which the intervention was performed and the availability of experienced staff to undertake the procedure)
- Cultural factors (for example, differences in standard care and differences in the welfare system)

Double-sifting

Titles and abstracts of identified studies were screened by two reviewers against inclusion criteria specified in the protocols, until a good inter-rater reliability was observed (percentage agreement ≥90% or Kappa statistics, K>0.60). Any disagreements between raters were 29 resolved through discussion. Initially 10% of references were double-screened. If inter-rater agreement was good then the remaining references were screened by one reviewer.

Once full versions of the selected studies were acquired for assessment, full studies were usually checked

independently by two reviewers, with any differences being resolved. For some review questions a random sample of papers was checked for inclusion. Any studies that failed to meet the inclusion criteria at this stage were excluded.

Unpublished Evidence

Stakeholders were invited to submit any relevant unpublished data using the call for evidence process set out in NICE (2014). The committee used a number of criteria when deciding whether or not to accept unpublished data. First, the evidence must have been accompanied by a trial report containing sufficient detail to properly assess risk of bias. Second, the evidence must have been submitted with the understanding that data from the study and a summary of the study's characteristics would be published in the full guideline. Therefore, in most circumstances the committee did not accept evidence submitted 'in confidence'. However, the committee recognised that unpublished evidence submitted by investigators might later be retracted by those investigators if the inclusion of such data would jeopardise publication of their research.

Health Economics Methods

Search Strategy for Economic Evidence

Scoping Searches

A broad preliminary search of the literature was undertaken in January 2015 to obtain an overview of the issues likely to be covered by the scope and help define key areas. Searches were restricted to economic studies and HTA reports and conducted in the following databases:

EMBASE
MEDLINE/MEDLINE In-Process
HTA database (technology assessments)
National Health Service Economic Evaluation Database (NHS EED).

Any relevant economic evidence arising from the clinical scoping searches was also made available to the health economist during the same period.

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered and a decision made to utilise a broad approach to searching to maximise retrieval of evidence to all parts of the guideline. Searches were restricted to economic studies and health technology assessment reports and conducted in the following databases:

EMBASE
HTA database (technology assessments)
MEDLINE/MEDLINE In-Process
NHS EED
PsycINFO

Any relevant economic evidence arising from the clinical searches was also made available to the health economist during the same period.

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces.

The search terms are set out in full in Appendix F. Full details of the search strategies and filter used for the systematic review of health economic evidence are provided in Appendix I.

Refer to Section 3.13.1 in the full version of the guideline for reference management, search filters, and date and language restrictions.

Inclusion Criteria for Economic Studies

The following inclusion criteria were applied to select studies identified by the economic searches for further consideration:

Only studies from Organisation for Economic Co-operation and Development countries were included, as the aim of the review was to identify economic information transferable to the UK context.
Only studies published from 2000 onwards were included in the review. This date restriction was imposed so that retrieved economic evidence was relevant to current healthcare settings and costs.
Selection criteria based on types of clinical conditions and service users as well as interventions assessed were identical to the clinical literature review.
Studies were included provided that sufficient details regarding methods and results were available to enable the methodological quality of the study to be assessed and provided that the study's data and results were extractable. Poster presentations of abstracts were excluded.
Full economic evaluations that compared two or more relevant options and considered both costs and consequences as well as costing analyses that compared only costs between two or more interventions were included in the review. Non-comparative studies were not considered in the review.
Economic studies were included if they used clinical effectiveness data from a clinical trial, a prospective or retrospective cohort study, or from a literature review. Studies with clinical effectiveness based on author's assumptions only were excluded.

Applicability and Quality Criteria for Economic Studies

All economic papers eligible for inclusion were appraised for their applicability and quality using the methodology checklist for economic evaluations recommended in the NICE *Guidelines Manual* (NICE, 2014). All studies that fully or partially met the applicability and quality criteria described in the methodology checklist were considered during the guideline development process. The completed methodology checklists for all economic evaluations considered in the guideline are provided in Appendix R.

Number of Source Documents

See Appendix K: Flow Charts (see the "Availability of Companion Documents" field) for information on results of literature searches and the number of included and excluded studies for each review question including economic article selection.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Overall Quality of Outcome Evidence in Grading of Recommendations Assessment, Development and Evaluation (GRADE)

Level	Description
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
Low	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
Very Low	Any estimate of effect is very uncertain.

Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Guideline Alliance (NGA) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Clinical Review Methods

Data Extraction

Quantitative Analysis

Study characteristics, aspects of methodological quality and outcome data were extracted from all eligible studies, using Review Manager Version 5.3.5 and an Excel-based form.

In most circumstances, for a given outcome (continuous and dichotomous), where more than 50% of the number randomised to any group were missing or incomplete, the study results were excluded from the analysis (except for the outcome 'leaving the study early', in which case, the denominator was the number randomised). Where there were limited data for a particular review, the 50% rule was not applied. In these circumstances the evidence was downgraded.

Where possible, outcome data from an intention-to-treat analysis (that is, a 'once-randomised-always-analyse' basis) were used. Where intention-to-treat had not been used or there were missing data, the effect size for dichotomous outcomes were recalculated using worse-case scenarios for positive outcome and vice versa (for example, it was assumed that the person whose data was missing did not achieve remission). Results reported at 12 months follow up (after the end of treatment) or as close as possible to 12 months were extracted. However, this was not always possible and outcomes up to 5 years after treatment were sometimes reported.

All continuous outcomes were presented as a standardised mean difference (SMD) instead of a mean difference (MD). The final scores in each group were the preferred outcome for extraction. If final or change scores (from the baseline) were not reported, for example, the study reported an F-value, p-value or t-value, the SMD was estimated if possible using a statistical calculator.

SMDs are typically used when different tools are used to measure the same outcome, for example, if depression is measured using either the Becks Depression Inventory or the Hospital Anxiety and Depression Scale. However, in this guideline SMDs were also used to present the results of continuous outcomes when the same tool was used, for example, eating psychopathology using the Eating Disorder Examination (EDE). The main reason for this is that the committee is apt at making decisions based on SMDs using the recommended interpretation of Cohen's effect size (d=0.2 small effect, d=0.5 moderate effect, d=0.7 large effect).

An outcome that had an SMD of ≥0.2 was considered clinically significant (or clinically important) and trends were discussed if the 95% confidence interval just crossed the line of no effect. This apparently low number of an SMD (≥0.2) was used as the threshold because of the small number of studies available and even small improvements on a scale that measures eating behaviour or mental health were considered clinically important for the person with an eating disorder.

The SMD results could have been converted back to MDs, however, no clinical consensus was made on

what constitutes a minimally important difference (MID) and no published MIDs were found for body weight or for the various eating disorder scales reported. Granted, there are methods available for estimating whether an MD is clinically important and there are published MIDs for various depression scales, however, the committee acknowledged there are limitations with both approaches (SMD and MD) and in order to make decisions across many comparisons, SMDs was the preferred approach.

For dichotomous outcomes, clinical significance was considered anything that was +/- ≥10% difference. Trends were discussed if the difference was +/- ≥10% but just crossed the line of no effect.

Refer to the full version of the guideline for additional information on quantitative analysis.

Evidence Synthesis

The method used to synthesise evidence depended on the review question and availability and type of evidence (see Appendix F for full details). Briefly, for questions about the psychometric properties of instruments, reliability, validity and clinical utility were synthesised narratively based on accepted criteria. For questions about test accuracy, bivariate test accuracy meta-analysis was conducted when there were data from four or more studies to calculate summary estimates of sensitivity and specificity for the relevant tool and threshold (if applicable). In the case where there were data from less than four studies, a narrative synthesis was presented. For questions about the effectiveness of interventions, standard meta-analysis was used where appropriate, otherwise narrative methods were used with clinical advice from the Committee. In the absence of high-quality research, formal and informal consensus processes were used.

Grading the Quality of Evidence

For questions about the effectiveness of interventions and the organisation and delivery of care, the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach was used to assess the quality of evidence for each outcome. The technical team produced GRADE evidence profiles (see below) using the GRADEpro guideline development tool, following advice set out in the GRADE handbook. All staff doing GRADE ratings were trained, and calibration exercises were used to improve reliability.

The analyses performed for existing systematic reviews incorporated into the guideline were not amended unless the committee considered that additional important aspects needed to be taken into consideration. For example, this could include stratifying data, conducting additional analyses, or using different results from the primary studies in a given analysis. Otherwise, the analyses were not amended.

For questions about what factors should be considered when admitting someone for compulsory treatment, a quality appraisal checklist of studies reporting correlations and associations was used. It is based on the appraisal step of the 'Graphical appraisal tool for epidemiological studies (GATE)'. This checklist enables a reviewer to appraise a study's internal and external validity after addressing the following key aspects of study design: characteristics of study participants; definition of independent variables; outcomes assessed and methods of analyses. An estimate of the overall quality was based on the average answer given to each of the checklists and given either very low, low, moderate or high quality (see the "Rating Scheme for the Strength of the Evidence" field).

Heterogeneity was explored if the I^2 test was greater than 50%. As described in the protocols, a sensitivity analysis was first conducted to see if studies that carried a high risk of bias explained the heterogeneity. If removing studies with a high risk of bias did not explain the results, then a subgroup analysis was conducted exploring the role duration of illness, severity of illness and presence of comorbidities. The full results of this are explained in the appendices and any subgroup analysis is shown in GRADE and explained in the linking evidence to recommendations (LETR) statement.

For observational studies included in any of the reviews, where randomised controlled trial evidence was not available, they were appraised using a quality appraisal checklist provided in the NICE manual 2012. This checklist assesses the study design, data collection, trustworthiness of the investigators, and the rigour of the analysis.

For questions about tools for case-identification and assessment of eating disorders (see Appendix M), a modified GRADE approach was used to produce an overall quality rating for the evidence according to the GRADE criteria of risk of bias, inconsistency, indirectness and imprecision. The default quality of evidence for cohort and cross-sectional studies was set as high quality; case-control studies were set as low quality since they overestimate the accuracy of tests due to spectrum bias. The QUADAS-2 checklist was used to evaluate risk of bias and indirectness. Whilst the QUADAS-2 framework does not provide an overall quality index for each study, such a rating was deemed important to assist the committee in interpreting the data on tools to augment assessment of mental health problems. The committee therefore adopted the terminology used within GRADE (high, moderate, low or very low quality evidence; see the "Rating Scheme for the Strength of the Evidence" field).

Refer to the full version of the guideline for more information on the quality of evidence grading.

Evidence Profiles

A GRADE evidence profile was used to summarise both the quality of the evidence and the results of the evidence synthesis for each 'critical' and 'important' outcome. The GRADE approach is based on a sequential assessment of the quality of evidence, followed by judgment about the balance between desirable and undesirable effects, and subsequent decision about the strength of a recommendation.

Within the GRADE approach to grading the quality of evidence, the following is used as a starting point:

> RCTs without important limitations provide high-quality evidence.
> Observational studies without special strengths or important limitations provide very low-quality evidence.

For each outcome, quality may be reduced depending on five factors: limitations, inconsistency, indirectness, imprecision and publication bias. For the purposes of the guideline, each factor was evaluated using criteria provided in Table 6 of the full version of the guideline.

For observational studies without any reasons for down-grading, the quality may be upgraded if there is a large effect, all plausible confounding would reduce the demonstrated effect (or increase the effect if no effect was observed), or there is evidence of a dose-response gradient (details would be provided under the 'other' column).

Each evidence profile includes a summary of findings: number of participants included in each group, an estimate of the magnitude of the effect, and the overall quality of the evidence for each outcome. Under the GRADE approach, the overall quality for each outcome is categorised into one of four groups (high, moderate, low, very low).

Presenting Evidence to the Guideline Committee

Study characteristics tables and, where appropriate, forest plots generated with Review Manager Version 5.3 and GRADE summary of findings tables (see Table 8 in the full version of the guideline) were presented to the Committee.

Where meta-analysis was not appropriate and/or possible, the reported results from each primary-level study were reported in the study characteristics table and presented to the Committee. The range of effect estimates were included in the GRADE profile and, where appropriate, described narratively.

Summary of Findings Tables

Summary of findings tables generated from GRADEpro were used to summarise the evidence for each outcome and the quality of that evidence (see Table 6 in the full version of the guideline). The tables provide anticipated comparative risks for dichotomous outcomes, which are especially useful when the baseline risk varies for different groups within the population.

Control group risks were not presented for SMDs as decisions on the clinical importance was based on the effect sizes independently of/regardless of the control risk. This would obviously not be the case for MDs.

Evidence Statements

Evidence statements provide a narrative of the results presented either in GRADE tables or other summary of evidence tables. For each outcome they describe what contributed to the overall result including the number of studies, the number of participants, the quality of the evidence, the direction of the effect and any uncertainty in the result. Subheadings were used to describe the intervention and comparison and if the result was found at the end of treatment or long-term follow-up. The evidence statements were used by the guideline committee to formulate and prioritise recommendations.

Extrapolation

When answering review questions, if there was no direct evidence from a primary dataset, based on the initial search for evidence, data was extrapolated from another data set as indirect evidence. Refer to the full version of the guideline for information on the principles used to determine when to extrapolate.

Health Economics Methods

The aim of the health economics was to contribute to the guideline's development by providing evidence on the cost-effectiveness of interventions and services covered in this guideline. This was achieved by a systematic literature review of existing economic evidence in all areas covered in the guideline.

Economic modelling was planned to be undertaken in areas with likely major resource implications, where the current extent of uncertainty over cost-effectiveness was significant and economic analysis was expected to reduce this uncertainty, in accordance with the NICE manual (NICE, 2014). Prioritisation of areas for economic modelling was a joint decision between the Health Economist and the Committee. The rationale for prioritising review questions for economic modelling was set out in an economic plan agreed between NICE, the Committee, the Health Economist and the other members of the technical team. The following economic questions were selected as key issues to be addressed by economic modelling:

- Cost-effectiveness of psychological therapies for adults with bulimia nervosa
- Cost-effectiveness of psychological individual therapies for adults with binge eating disorder
- Cost-effectiveness of psychological group therapies for adults with binge eating disorder

In addition, literature on the health-related quality of life (HRQoL) of people covered by this guideline was systematically searched to identify studies reporting appropriate utility scores that could be utilised in a cost-utility analysis.

In areas where modelling was not possible, the committee took into consideration resource implications and anticipated the cost-effectiveness of interventions and services for people with eating disorders when making recommendations.

Presentation of Economic Evidence

The economic evidence considered in the guideline is provided in the respective evidence chapters, following presentation of the relevant clinical evidence. The references to included studies and the respective evidence tables with the study characteristics and results are provided in Appendix S. Characteristics and results of all economic studies considered during the guideline development process are summarised in economic evidence profiles provided in Appendix T. The full guideline includes only a brief summary of *de-novo* economic modelling undertaken. The detailed write up of *de-novo* economic models including the methods and full results are presented in the Appendix X.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Guideline Alliance (NGA) on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Who Developed the Guideline?

A multidisciplinary committee comprising healthcare professionals, researchers and lay members developed this guideline. The group met every four to six weeks during the development of the guideline. Staff from the National Guideline Alliance (NGA) provided methodological support and guidance for the development process. The team working on the guideline included a guideline lead, a project manager, systematic reviewers, health economists and information scientists. They undertook systematic searches of the literature, appraised the evidence, conducted meta-analysis and cost-effectiveness analysis where appropriate and drafted the guideline in collaboration with the committee.

The Guideline Committee

During the scope consultation phase, members of the committee were appointed by an open recruitment process. Committee membership consisted of: professionals in psychiatry, clinical psychology, nursing, social work, general practice; academic experts in psychiatry and psychology; and service users and carers. The guideline development process was supported by staff from the NGA, who undertook the clinical and health economic literature searches, reviewed and presented the evidence to the committee, managed the process and contributed to drafting the guideline.

Guideline Committee Meetings

There were 12 committee meetings, held between May 2015 and July 2016. During each day-long committee meeting, in a plenary session, review questions and clinical and economic evidence were reviewed and assessed and recommendations formulated.

Service Users and Carers

The committee included one carer member and two service users who contributed as full committee members to writing the review questions, providing advice on outcomes most relevant to service users and carers, helping to ensure that the evidence addressed their views and preferences, highlighting sensitive issues and terminology relevant to the guideline and bringing service user research to the attention of the committee. Input from both service users and carers was central to the development of the guideline and they contributed to writing the guideline's introduction and the recommendations from the service user and carer perspective.

Expert Advisers

No Expert Advisors were used in the development of this guideline.

National and International Experts

National and international experts in the area under review were identified through the literature search and through the experience of the committee members. These experts were contacted to identify unpublished or soon-to-be published studies, to ensure that up-to-date evidence was included in the development of the guideline. They informed the committee about completed trials at the pre-publication stage, systematic reviews in the process of being published, studies relating to the cost-effectiveness of treatment and trial data if the committee could be provided with full access to the complete trial report. Appendix E lists researchers who were contacted.

Review Protocols

Review questions drafted during the scoping phase were discussed by the committee at the first few meetings and amended as necessary. The review questions were used as the starting point for

developing review protocols for each systematic review. The final list of review questions can be found in Appendix F.

For questions about interventions, the PICO (Population, Intervention, Comparison and Outcome) framework was used to structure each question (see Table 3 in the full version of the guideline).

Questions relating to case identification and assessment tools and methods do not involve an intervention designed to treat a particular condition and therefore the PICO framework was not used. Rather, the questions were designed to pick up key issues specifically relevant to clinical utility, for example their accuracy, reliability, safety and acceptability to the service user.

In some situations, review questions related to issues of service delivery are occasionally specified in the remit from the Department of Health. In these cases, appropriate review questions were developed to be clear and concise.

For each topic, addressed by one or more review questions, a review protocol was drafted by the technical team using a standardised template (based on the PROSPERO database of systematic reviews in health), review and agreed by the committee (all protocols are included in Appendix F).

To help facilitate the literature review, a note was made of the best study design type to answer each question. There are five main types of review question of relevance to NICE guidelines. These are listed in Table 4 in the full version of the guideline. For each type of question, the best primary study design varies, where 'best' is interpreted as 'least likely to give misleading answers to the question'. For questions about the effectiveness of interventions, where randomised controlled trials (RCTs) were not available, the review of other types of evidence was pursued only if there was reason to believe that it would help the committee to formulate a recommendation. However, in all cases, a well-conducted systematic review (of the appropriate type of study) is likely to always yield a better answer than a single study.

Clinical Review Methods

The aim of the clinical literature review was to systematically identify and synthesise relevant evidence from the literature in order to answer the specific review questions developed by the Committee. Thus, clinical practice recommendations are evidence-based, where possible, and, if evidence is not available, either formal or informal consensus methods are used to try and reach general agreement between committee members and the need for future research is specified.

Informal Method of Consensus

The informal consensus process involved a group discussion of what is known about the issues. The views of the committee were synthesised narratively by a member of the review team and circulated after the meeting. Feedback was used to revise the text, which was then included in the appropriate evidence review chapter.

From Evidence to Recommendations

Once the clinical and health economic evidence was summarised, the committee drafted the recommendations. In making recommendations, the committee took into account the trade-off between the benefits and harms of the intervention/instrument, as well as other important factors, such as the relative value of different outcomes reported in the evidence, quality of the evidence, trade-off between net health benefits and resource use, values and experience of the committee and society, current clinical practice, the requirements to prevent discrimination and to promote equality and the committee's awareness of practical issues.

Finally, to show clearly how the committee moved from the evidence to the recommendations, each chapter (or sub-section) has a section called 'recommendations and link to evidence'. Underpinning this section is the concept of the 'strength' of a recommendation. Some recommendations are 'strong' in that the committee believes that the vast majority of healthcare professionals and service users would choose a particular intervention if they considered the evidence in the same way that the committee has. This is

generally the case if the benefits clearly outweigh the harms for most people and the intervention is likely to be cost effective. However, there is often a closer balance between benefits and harms and some service users would not choose an intervention whereas others would. This may happen, for example, if some service users are particularly averse to some side effect and others are not. In these circumstances the recommendation is generally weaker, although it may be possible to make stronger recommendations about specific groups of service users. The strength of each recommendation is reflected in the wording of the recommendation, rather than by using ratings, labels or symbols. For example a recommendation will use the words 'consider' or 'offer' a type of treatment, reflecting a weaker versus a stronger recommendation respectively.

Where the committee identified areas of uncertainty or where robust evidence was lacking, they developed research recommendations. Those that were identified as 'high priority' were developed further in the NICE version of the guideline and presented in Appendix G.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

Some recommendations can be made with more certainty than others, depending on the quality of the underpinning evidence. The Committee makes a recommendation based on the trade-off between the benefits and harms of a system, process or an intervention, taking into account the quality of the underpinning evidence. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The Committee usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally the Committee uses 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The Committee uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of people, a system, process or an intervention will do more good than harm, and be cost effective. Similar forms of words (for example, 'Do not offer…') are used when the Committee is confident that an intervention will not be of benefit for most people.

Interventions That Could Be Used

The Committee uses 'consider' when confident that a system, process or an intervention will do more good than harm for most people, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the person's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the person.

Cost Analysis

Refer to the "Economic evidence statements" and "Trade-off between net health benefits and resource use" sections in the full version of the guideline as well as Appendices P and Q for health economics evidence tables and Appendix R for the network (mixed treatment comparison) meta-analytic methods used in the economic analysis. In addition, Appendix S provides the results of economic modelling interventions for people with bulimia nervosa (BN). The cost-effectiveness of interventions for adults with BN was considered by the committee as an area with likely significant resource implications. Existing economic evidence on the cost-effectiveness of psychological therapies for adults with BN was limited to 1 United States (US) study that is not directly applicable to the UK setting and did not assess the whole range of treatments available in the UK. Therefore, an economic analysis was undertaken to assess the

cost-effectiveness of treatments for adults with BN. See the "Availability of Companion Documents" field for the full version of the guideline and all appendices.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Validation of the Guideline

This guidance is subject to a six week public consultation and feedback as part of the quality assurance and peer review of the document. All comments received from registered stakeholders are responded to in turn and posted on the National Institute for Health and Care Excellence (NICE) Web site when the pre-publication check of the full guideline occurs.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The type of evidence supporting each review area is detailed in the full version of the guideline (see the "Availability of Companion Documents" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Eating disorders are poorly identified in non-specialist National Health Service (NHS) settings. These disorders are usually long-lasting and have serious implications, including risk of death, impaired health, psychiatric comorbidity and poor quality of life for the patient and those around them. There is now far more evidence of efficacious treatments (both physical and psychological) for eating disorders. It has become clear that clinicians vary substantially in their identification of cases and their delivery of the evidence-based treatments that are recommended.

Refer to the "Trade-off between benefits and harms" sections of the full version of the guideline (see the "Availability of Companion Documents" field) for details about benefits of specific interventions.

Potential Harms

- When medication is used to treat people with severe eating disorders, the side effects of the drugs (in particular, cardiac side effects) should be carefully considered because of the compromised cardiovascular function of many people with anorexia nervosa.
- Bisphosphonates used in the treatment of osteoporosis are associated with the risk of teratogenic effects.

Refer to the "Trade-off between benefits and harms" sections of the full version of the guideline (see the "Availability of Companion Documents" field) for details about potential harms of specific interventions.

Qualifying Statements

Qualifying Statements

- The recommendations in this guideline represent the view of the National Institute for Health and Care Excellence (NICE), arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.
- Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.
- Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Implementation of the Guideline

Description of Implementation Strategy

The National Institute for Health and Care Excellence (NICE) has produced tools and resources to help put this guideline into practice (see also the "Availability of Companion Documents" field).

Implementation Tools

Clinical Algorithm

Mobile Device Resources

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Eating disorders: recognition and treatment. London (UK): National Institute for Health and Care Excellence (NICE); 2017 May 23. 41 p. (NICE guideline; no. 69).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017 May 23

Guideline Developer(s)

National Guideline Alliance - National Government Agency [Non-U.S.]

Source(s) of Funding

The National Institute for Health and Care Excellence (NICE) funds the National Guideline Alliance (NGA) and thus supported the development of this guideline.

Guideline Committee

Guideline Committee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

At the start of the guideline development process all group members declared interests including consultancies, fee-paid work, shareholdings, fellowships and support from the healthcare industry. At all subsequent group meetings, members declared arising conflicts of interest. Members were either required to withdraw completely or for part of the discussion if their declared interest made it appropriate. In such cases, the relevant members were sometimes consulted for points of clarification only and did not play a role in the committee's decision making. The details of declared interests and the actions taken are shown in Appendix B in the full guideline appendices (see the "Availability of Companion Documents" field).

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: National Collaborating Centre for Mental Health. Eating disorders. Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. Leicester (UK): British Psychological Society; 2004. 260 p. [408 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the National Institute for Health and Care Excellence (NICE) Web site . Also available for download in eBook and ePub formats from the NICE Web site .

Availability of Companion Documents

The following are available:

Eating disorders: recognition and treatment. Full guideline. London (UK): National Institute for Health and Care Excellence; 2017 May. 970 p. (NICE guideline; no. 69). Available from the National Institute for Health and Care Excellence (NICE) Web site .

Eating disorders: recognition and treatment. Appendices. London (UK): National Institute for Health and Care Excellence; 2017 May. (NICE guideline; no. 69). Available from the NICE Web site .

Eating disorders: recognition and treatment. Baseline assessment tool. London (UK): National Institute for Health and Care Excellence; 2017 May. (NICE guideline; no. 69). Available from the NICE Web site .

Eating disorders: recognition and treatment. Resource impact report. London (UK): National Institute for Health and Care Excellence; 2017 May. 10 p. (NICE guideline; no. 69). Available from the NICE Web site .

Eating disorders: recognition and treatment. Resource impact template. London (UK): National Institute for Health and Care Excellence; 2017 May. (NICE guideline; no. 69). Available from the NICE Web site .

The guidelines manual 2012. London (UK): National Institute for Health and Care Excellence (NICE); 2012 Nov. Available from the NICE Web site .

Developing NICE guidelines: the manual. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Oct. Available from the NICE Web site .

Patient Resources

The following is available:

Eating disorders: recognition and treatment. Information for the public. London (UK): National Institute for Health and Care Excellence (NICE); 2017 May. 22 p. Available from the NICE Web site . Also available for download in eBook and ePub formats from the NICE Web site .

NGC Status

This NGC summary was completed by ECRI on January 4, 2005. The information was verified by the guideline developer on March 9, 2005. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI Institute on November 6, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This summary was updated by ECRI Institute on June 21, 2017.

This NEATS assessment was completed by ECRI Institute on July 19, 2017. The guideline developer did not acknowledge or provide confirmation for this NEATS assessment.

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